



FEB 26 2007

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Inspector General

SUBJECT: Review of Hospital Wage Data Used To Calculate Inpatient Prospective Payment System Wage Indexes (A-01-05-00504)

Attached is our final report on hospital wage data used to calculate inpatient prospective payment system wage indexes. Our objectives were to (1) consolidate the results of our reviews of 21 hospitals' compliance with Medicare requirements for reporting wage data and (2) identify possible Centers for Medicare & Medicaid Services (CMS) remedies to address reporting errors. We reviewed wage data reported by 2 hospitals in their fiscal year (FY) 2000 cost reports, 1 hospital in its FY 2001 cost report, 12 hospitals in their FY 2003 cost reports, and 2 hospitals in their FY 2004 cost reports. In addition, we performed limited-scope reviews of deferred compensation wage data reported by four hospitals in their FY 2004 cost reports.

CMS adjusts prospective payments by the wage index applicable to the area in which each hospital is located. To calculate wage indexes, CMS uses hospital wage data collected 4 years earlier to allow time for the collection of complete cost report data from all inpatient prospective payment system hospitals and for reviews of hospital wage data by CMS's fiscal intermediaries. For example, CMS based the FY 2007 wage indexes on wage data collected from hospitals' Medicare cost reports for their FYs that began during Federal FY 2003. CMS bases each wage index on the average hourly wage rate of the applicable hospitals divided by the national average rate.

CMS is required to update wage indexes annually in a manner that ensures that aggregate payments to hospitals are not affected by changes in the indexes. CMS is also required to update payments to hospitals by an applicable percentage based on the market basket index, which measures the inflationary increases in hospital costs. Hospitals must accurately report wage data for CMS to determine the equitable distribution of payments and ensure the appropriate level of funding to cover hospital costs.

The 21 hospitals that we reviewed reported wage data totaling \$377.9 million that did not comply with Medicare requirements. Specifically, these hospitals reported misstated, unsupported, unallowable, and misclassified wages and other costs, as well as related hours.

These errors occurred because the hospitals did not sufficiently review and reconcile their reported wage data to supporting documentation to ensure that the data were accurate, supportable, and in compliance with Medicare requirements. The fiscal intermediaries' cost report reviews did not detect the errors because their review procedures were generally limited in scope. As a result, 17 of the 21 hospitals overstated their average hourly wage rates by 0.23 percent to 21 percent. The remaining four hospitals understated their average hourly wage rates by 0.62 percent to 28 percent.

Generally, hospitals that overstate wage data will receive higher Medicare reimbursement at the expense of hospitals that report accurate or understated wage data. The inclusion of unallowable costs in cost reports can also compromise the reliability of the wage data that CMS uses to develop the market basket index and the labor-related share. CMS uses the labor-related share in conjunction with the wage index to determine the geographic adjustment for hospital payments.

We recommend that CMS develop a corrective action plan to address hospitals' errors in reporting wage data. As part of its action plan, CMS should consider:

- ensuring that its FY 2007 wage indexes were adjusted, and its FY 2008 wage indexes will be adjusted, as appropriate, to account for the inaccurate wage data identified in our individual reviews;
- working with its fiscal intermediaries to encourage hospitals to implement review and reconciliation procedures to ensure that reported wage data are accurate, supportable, and in compliance with Medicare requirements;
- alerting its fiscal intermediaries to the results of our reviews and recommending that they consider those results in prioritizing areas to examine in future cost report reviews; and
- working with its fiscal intermediaries to develop techniques for identifying hospitals at high risk of reporting inaccurate wage data and instructing the intermediaries to conduct more detailed reviews at those hospitals.

In its comments on our draft report, CMS concurred with the recommendations.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov. Please refer to report number A-01-05-00504 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HOSPITAL WAGE
DATA USED TO CALCULATE
INPATIENT PROSPECTIVE
PAYMENT SYSTEM
WAGE INDEXES**



Daniel R. Levinson
Inspector General

February 2007
A-01-05-00504

Office of Inspector General

<http://oig.hhs.gov>

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The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

Under the inpatient prospective payment system for acute-care hospitals, Medicare Part A pays hospital costs at predetermined, diagnosis-related rates for patient discharges. The Centers for Medicare & Medicaid Services (CMS) adjusts prospective payments by the wage index applicable to the area in which each hospital is located. CMS calculates a wage index for each metropolitan area, known as a core-based statistical area, as well as a statewide rural wage index for each State. These calculations use hospital wage data (which include wages, salaries, and related hours) collected 4 years earlier to allow time for the collection of complete cost report data from all inpatient prospective payment system hospitals and for reviews of hospital wage data by CMS's fiscal intermediaries. For example, CMS based the fiscal year (FY) 2007 wage indexes on wage data collected from hospitals' Medicare cost reports for their FYs that began during Federal FY 2003.

CMS bases each wage index on the average hourly wage rate of the applicable hospitals divided by the national average rate. A hospital's wage rate is the quotient of dividing total dollars (numerator) by total hours (denominator). Arriving at the final numerator and denominator in this rate computation involves a series of calculations.

CMS is required to update wage indexes annually in a manner that ensures that aggregate payments to hospitals are not affected by changes in the indexes. CMS is also required to update payments to hospitals by an applicable percentage based on the market basket index, which measures the inflationary increases in hospital costs. Hospitals must accurately report wage data for CMS to determine the equitable distribution of payments and ensure the appropriate level of funding to cover hospital costs.

We reviewed wage data reported by 21 hospitals. Our reviews covered 2 hospitals' FY 2000 cost reports, 1 hospital's FY 2001 cost report, 12 hospitals' FY 2003 cost reports, and 2 hospitals' FY 2004 cost reports. In addition, we performed limited-scope reviews of deferred compensation wage data reported by four hospitals in their FY 2004 cost reports.

OBJECTIVES

Our objectives were to (1) consolidate the results of our reviews of 21 hospitals' compliance with Medicare requirements for reporting wage data and (2) identify possible CMS remedies to address reporting errors.

SUMMARY OF FINDINGS

The 21 hospitals reviewed did not fully comply with Medicare requirements for reporting wage data in their Medicare cost reports. Specifically, these hospitals reported the following inaccurate wage data totaling \$377.9 million, which affected the numerator and/or denominator of their wage rate calculations:

- overstated pension and other postretirement benefit costs totaling \$326.4 million;
- misstated wages, fringe benefit costs, and home office and nonsalary costs totaling \$18.5 million and 293,000 hours;
- misstated and unsupported costs for contract labor services totaling \$13.2 million and 241,000 hours;
- costs for unallowable Part B services totaling \$10.5 million and 158,000 hours; and
- misstated and misclassified wages totaling \$9.3 million and 1.5 million hours.

These errors occurred because the hospitals did not sufficiently review and reconcile their reported wage data to supporting documentation to ensure that the data were accurate, supportable, and in compliance with Medicare requirements. The fiscal intermediaries' cost report reviews did not detect the errors because their review procedures were generally limited in scope. As a result, 17 of the 21 hospitals overstated their average hourly wage rates by 0.23 percent to 21 percent. The remaining four hospitals understated their average hourly wage rates by 0.62 percent to 28 percent.

Generally, hospitals that overstate wage data will receive higher Medicare reimbursement at the expense of hospitals that report accurate or understated wage data. The inclusion of unallowable costs in cost reports can also compromise the reliability of the wage data that CMS uses to develop the market basket index and the labor-related share. CMS uses the labor-related share in conjunction with the wage index to determine the geographic adjustment for hospital payments.

RECOMMENDATIONS

We recommend that CMS develop a corrective action plan to address hospitals' errors in reporting wage data. As part of its action plan, CMS should consider:

- ensuring that its FY 2007 wage indexes were adjusted, and its FY 2008 wage indexes will be adjusted, as appropriate, to account for the inaccurate wage data identified in our individual reviews;
- working with its fiscal intermediaries to encourage hospitals to implement review and reconciliation procedures to ensure that reported wage data are accurate, supportable, and in compliance with Medicare requirements;
- alerting its fiscal intermediaries to the results of our reviews and recommending that they consider those results in prioritizing areas to examine in future cost report reviews; and
- working with its fiscal intermediaries to develop techniques for identifying hospitals at high risk of reporting inaccurate wage data and instructing the intermediaries to conduct more detailed reviews at those hospitals.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its comments on our draft report, CMS agreed with the recommendations. We have included CMS's comments as Appendix C.

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INTRODUCTION

BACKGROUND

Medicare Inpatient Prospective Payment System

Under the inpatient prospective payment system for acute-care hospitals, Medicare Part A pays hospital costs at predetermined, diagnosis-related rates for patient discharges. In fiscal year (FY) 2007, the Centers for Medicare & Medicaid Services (CMS) expects Medicare Part A to pay inpatient hospitals approximately \$112.7 billion.

Wage Indexes

The geographic designation of hospitals influences their Medicare payments. Under the inpatient prospective payment system, CMS adjusts payments through wage indexes to reflect labor cost variations among localities.¹ CMS uses the Office of Management and Budget (OMB) metropolitan area designations to identify labor markets and to calculate and assign wage indexes to hospitals. In 2003, OMB revised its metropolitan statistical area definitions and announced new core-based statistical areas (CBSA). CMS calculates a wage index for each CBSA and a statewide rural wage index for each State. The wage index for each CBSA and statewide rural area is based on the average hourly wage rate of the hospitals in those areas divided by the national average hourly wage rate. All hospitals within a CBSA or within a statewide rural area receive the same labor payment adjustment.

To calculate wage indexes, CMS uses hospital wage data (which include wages, salaries, and related hours) collected 4 years earlier to allow time for the collection of complete cost report data from all inpatient prospective payment system hospitals and for reviews of hospital wage data by CMS's fiscal intermediaries. For example, CMS based the wage indexes for FY 2007, which began October 1, 2006, on wage data collected from hospitals' Medicare cost reports for their FYs that began during Federal FY 2003. A hospital's wage rate is the quotient of dividing total dollars (numerator) by total hours (denominator). Arriving at the final numerator and denominator in this rate computation involves a series of calculations. Inaccuracies in either the dollar amounts or hours reported can have varying effects on the final rate computation.

Section 1886(d)(3)(E) of the Social Security Act (the Act) requires that CMS update wage indexes annually in a manner that ensures that aggregate payments to hospitals are not affected by changes in the indexes. Hospitals must accurately report wage data for CMS to determine the equitable distribution of payments. Further, section 1886(d)(3)(A)(iv) of the Act requires CMS to update labor and nonlabor average standardized amounts by an applicable percentage increase specified in section 1886(b)(3)(B)(i). The percentage increase is based on the market basket index, which measures the inflationary increases in hospital costs. The inclusion of unallowable costs in wage data could produce an inaccurate market basket index for updating prospective payments to hospitals.

¹The inpatient prospective payment system wage index or a modified version also applies to other providers, such as outpatient hospitals, long term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, skilled nursing facilities, home health agencies, and hospices.

Fiscal Intermediaries' Cost Report Reviews

CMS contracts with 35 fiscal intermediaries nationwide to review and settle hospitals' annual Medicare cost reports. The cost reports contain several components, including wage data, that determine inpatient hospital reimbursement. The intermediaries focus their limited resources on the cost report components that materially affect the current year's Medicare reimbursement. Because the current year's cost report settlement and reimbursement are not contingent on the validity of reported wage data, intermediaries limit their review of wage data to specific areas and unresolved data elements identified by CMS's system edits. However, inaccurate wage data could result in payment inequities 4 years after hospitals submit their cost reports.

Prior Office of Inspector General Work

In May 2005, we alerted CMS to our preliminary findings regarding hospitals' inconsistent reporting of pension and other postretirement benefit costs as wage data in their cost reports. While some hospitals included millions of dollars in unfunded pension and other postretirement benefit costs in their annual wage data, others included only funded amounts. In its inpatient prospective payment system final rule (70 Federal Register 47369, August 12, 2005), CMS clarified its existing policy that hospitals must comply with the "Medicare Provider Reimbursement Manual" (the Manual) and Medicare instructions for reporting deferred compensation costs as wage-related costs. The Manual and Medicare instructions require that pension and other postretirement benefit costs be liquidated in a timely manner to be properly reported as wage-related costs.

In FYs 2005 and 2006, we issued individual wage data reports to 21 selected hospitals in nine States and provided copies to CMS. (See Appendix A.)

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to (1) consolidate the results of our reviews of 21 hospitals' compliance with Medicare requirements for reporting wage data and (2) identify possible CMS remedies to address reporting errors.

Scope

This consolidated report addresses the most significant findings from our reviews of the 21 hospitals. We selected these hospitals for review based on several risk factors, as shown in Appendix B. The 21 hospitals reported salaries totaling approximately \$3.66 billion and hours totaling 101.4 million on worksheet S-3, parts II and III, of their Medicare cost reports for the FYs reviewed. The FY 2003 wage data reported by the 21 hospitals could affect 334 hospitals in 18 CBSAs and, in total, could influence FY 2007 Medicare payments for approximately 1 million of the 11.3 million discharges nationally, or approximately 9 percent of all discharges. We reviewed wage data reported by 2 hospitals in their FY 2000 cost reports, 1 hospital in its FY 2001 cost report, 12 hospitals in their FY 2003 cost reports, and 2 hospitals in their FY 2004 cost reports. In addition, we performed limited-scope reviews of deferred compensation wage

data reported by four hospitals in their FY 2004 cost reports. We limited our review of hospitals' internal controls to the procedures for accumulating and reporting wage data in Medicare cost reports.

We performed fieldwork at the 21 hospitals in California, Connecticut, Florida, Illinois, Massachusetts, New York, New Jersey, Pennsylvania, and Texas from January 2004 through February 2006. We also performed fieldwork at the selected hospitals' fiscal intermediaries.

Methodology

To accomplish our objectives, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- met with CMS officials before we selected hospitals for review to discuss CMS's wage data protocols, fiscal intermediaries' wage data review procedures, and aspects of hospitals' reported wage data that are vulnerable to error;
- gained an understanding of the selected hospitals' procedures for reporting wage data;
- met with the applicable fiscal intermediaries to review their adjustments to the wage data included in the selected hospitals' Medicare cost reports;
- verified that wage data on the selected hospitals' trial balances reconciled to their audited financial statements;
- reconciled the total wages reported in the selected hospitals' Medicare cost reports to their trial balances;
- reconciled the wage data from selected cost centers to detailed support, such as payroll registers or accounts payable invoices;
- selected for testing wage data from cost centers that accounted for at least 2 percent of each of the selected hospitals' wages;
- tested a sample of transactions from the cost centers and reconciled wage data to payroll records;
- interviewed staff at the selected hospitals about the nature of services that employees and contracted labor provided to the hospitals;
- determined the effect of reporting errors by recalculating the selected hospitals' average hourly wage rates using the CMS methodology for calculating wage indexes, which includes an hourly overhead factor pursuant to instructions published in the Federal Register;

- provided the fiscal intermediaries with our audit adjustments after we completed our fieldwork; and
- discussed the results of our reviews with CMS officials.

We conducted our reviews in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The 21 hospitals reviewed did not fully comply with Medicare requirements for reporting wage data in their Medicare cost reports. Specifically, these hospitals reported the following inaccurate wage data totaling \$377.9 million, which affected the numerator and/or denominator of their wage rate calculations:

- overstated pension and other postretirement benefit costs totaling \$326.4 million;
- misstated wages, fringe benefit costs, and home office and nonsalary costs totaling \$18.5 million and 293,000 hours;
- misstated and unsupported costs for contract labor services totaling \$13.2 million and 241,000 hours;
- costs for unallowable Part B services totaling \$10.5 million and 158,000 hours; and
- misstated and misclassified wages totaling \$9.3 million and 1.5 million hours.

These errors occurred because the hospitals did not sufficiently review and reconcile their reported wage data to supporting documentation to ensure that the data were accurate, supportable, and in compliance with Medicare requirements. The fiscal intermediaries' cost report reviews did not detect the errors because their review procedures were generally limited in scope. As a result, 17 of the 21 hospitals' reported wage data overstated their average hourly wage rates by 0.23 percent to 21 percent. The remaining four hospitals' reported wage data understated their average hourly wage rates by 0.62 percent to 28 percent.

Generally, hospitals that overstate wage data will receive higher Medicare reimbursement at the expense of hospitals that report accurate or understated data. The inclusion of unallowable costs in cost reports can also compromise the reliability of the wage data that CMS uses to develop the market basket index and the labor-related share. CMS uses the labor-related share in conjunction with the wage index to determine the geographic adjustment for hospital payments.

ERRORS IN REPORTED WAGE DATA

Overstated Pension and Other Postretirement Benefit Costs

The Manual, part II, section 3605.2, states that “for purposes of determining the wage-related costs for the wage index, a hospital must use generally accepted accounting principles (GAAP).”

GAAP provisions governing pension plans include the use of an accrual basis of accounting for contributions to a plan, so that plan liabilities need not be “liquidated” by actual cash transfers to the plan.

However, in June 2003, CMS clarified in a note to section 3605.2 that, “[a]lthough hospitals should use GAAP in developing wage related costs, the amount reported for wage index purposes must meet the reasonable cost provisions of Medicare.”² Medicare reasonable cost principles differ from certain GAAP provisions by requiring a “cash” basis of accounting where the provider is obligated to make cash payments to the fund and to liquidate all liabilities on a timely basis.

For example, the Manual, part I, section 2142, states that, for a plan to be considered funded for the purposes of Medicare cost reimbursement, the liability must have been determined and the provider must have been obligated to make payments to the fund. Federal regulations setting forth the principles of reasonable cost reimbursement state: “Reasonable provider payments made under unfunded deferred compensation plans are included in allowable costs only during the cost reporting period in which actual payment is made to the participating employee” (42 CFR § 413.100(c)(2)(vii)(A)). In addition, 42 CFR § 413.100(c)(2)(vii)(B) states: “Accrued liability related to contributions to a funded deferred compensation plan must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred.” Further, 42 CFR § 413.100(c)(2)(vii)(C) states: “Postretirement benefit plans . . . are deferred compensation arrangements and thus are subject to the provisions of this section regarding deferred compensation and to applicable program instructions”

Of the 21 hospitals reviewed, 9 overstated their wage data by a total of \$326.4 million by reporting unliquidated pension and/or other postretirement benefit costs. Seven of the nine hospitals incorrectly reported both unliquidated pension costs and other unliquidated postretirement benefit costs, one incorrectly reported unliquidated pension costs only, and one incorrectly reported other unliquidated postretirement benefit costs only.

Overstated Pension Costs

Eight hospitals incorrectly reported unliquidated pension costs, which overstated their wage data by a total of \$168.5 million.³ The hospitals used GAAP to determine pension costs reported in their Medicare cost reports. However, the hospitals either (1) had not liquidated the entire amounts associated with these costs within 1 year of the applicable cost-reporting period or (2) had no obligation to make additional contributions to their pension plans because the plans were already fully funded as a result of prior contributions or plan investment earnings. For instance, one hospital’s FY 2004 cost report included \$50.7 million of pension costs that had been actuarially determined in accordance with GAAP. However, the hospital had not contributed to the pension plan during FY 2004 because the plan was already fully funded.

²We applied the requirement that wage-related costs be reported according to Medicare principles only to those selected hospitals for which cost reports were submitted after June 2003, i.e., those submitted for FY 2003 or later.

³Ten of the twenty-one hospitals that we reviewed correctly reported only liquidated pension costs, and the remaining three hospitals did not report any pension costs.

Because the hospital had not recorded a contribution or pension cost liability, it should not have reported these unliquidated pension costs as wage-related costs in its cost report.

Other Overstated Postretirement Benefit Costs

Eight hospitals incorrectly reported other unliquidated postretirement benefit costs, which overstated their wage data by a total of \$157.9 million.⁴ Although the hospitals used GAAP to determine postretirement benefit costs, these costs had not yet been funded and may never be funded. For instance, one hospital's FY 2004 cost report included \$36.5 million in postretirement benefit costs that had been actuarially determined in accordance with GAAP. However, the hospital did not have a trust fund for postretirement benefits. Instead, the hospital paid postretirement benefit costs as they were incurred, and its actual postretirement benefit costs in FY 2004 totaled \$7.1 million rather than the \$36.5 million reported.

Effect on Average Hourly Wage Rates

The table below shows the FY wage index affected by unliquidated pension and other postretirement benefit costs at each of the nine hospitals that reported these costs and the percentage reduction in each hospital's average hourly wage rate after we deducted the unallowable costs.

Effect of Overstated Pension and Other Postretirement Benefit Costs on the Average Hourly Wage Rates at Nine Hospitals

Hospital	FY Wage Index Affected	Unliquidated Pension Costs	Other Unliquidated Postretirement Benefit Costs	Total Unallowable Costs	Reduction in Average Hourly Wage Rate When Corrected
1	2004	—	\$1,542,387	\$1,542,387	5%
2	2005	\$3,471,872	—	3,471,872	2%
3	2007	475,390	46,878	522,268	1%
4	2007	726,256	2,952,058	3,678,314	1%
5	2007	11,391,824	19,981,545	31,373,369	14%
6	2007	48,714,198	28,305,943	77,020,141	16%
7	2007	22,185,436	25,587,883	47,773,319	19%
8	2007	32,913,318	38,116,937	71,030,255	19%
9	2007	48,626,469	41,393,742	90,020,211	21%
Total		\$168,504,763	\$157,927,373	\$326,432,136	

Misstated Wages, Fringe Benefit Costs, and Home Office and Nonsalary Costs

The Manual, part II, section 3605.2, requires hospitals to ensure that the wage data reported in their Medicare cost reports are accurate and exclude wages incurred for skilled nursing facility services and rural health clinic services; direct personnel costs for interns and residents; and costs

⁴Thirteen of the twenty-one hospitals that we reviewed did not report any postretirement benefit costs.

for equipment, supplies, travel, and overhead items. This section also requires hospitals to report wage-related fringe benefit costs as listed on Exhibit 7, which is a standardized core list of wage-related benefit costs. Further, part I, section 2136.2, states that certain advertising costs should be excluded from wage index calculations. These unallowable advertising costs include the costs of recruiting physicians, selling stocks, and increasing the use of services.

Of the 21 hospitals reviewed, 15 misstated wages, fringe benefit costs, and/or home office and nonsalary costs.⁵ These wage data reporting errors totaled \$18.5 million and 293,000 hours.

- Seven hospitals included unallowable fringe benefit costs for excluded areas and for Part B physician and nurse practitioner salaries erroneously reported as Part A costs, which overstated their average hourly wage rates.
- Six hospitals included unallowable wages for fundraising, outreach programs, advertising, day care, and rural health clinics, which overstated their average hourly wage rates.
- Five hospitals included unallowable home office salaries and related fringe benefit and nonsalary costs, which overstated their average hourly wage rates.
- Two hospitals omitted fringe benefit costs related to allowable salaries, which understated their average hourly wage rates.

Misstated and Unsupported Costs for Contract Labor Services

The Manual, part II, section 3605.2, states that the amounts paid for services furnished under contract are allowable if they are for direct patient care. These allowable services include nursing, diagnostic, therapeutic, and rehabilitative services and certain management services. The Manual limits allowable contract management services to personnel costs for hospital executive officers and nursing administrators. The Manual also states that unallowable contract labor includes costs for equipment, supplies, travel, and other miscellaneous or overhead items. In addition, 42 CFR § 413.20 requires providers to maintain sufficient financial records and statistical data for proper determination of costs payable under the program.

Of the 21 hospitals reviewed, 13 misstated or could not support reported costs for contract labor services.⁶ These wage data reporting errors totaled \$13.2 million and 241,000 hours.

- Nine hospitals included unsupported contract labor services, which overstated the average hourly wage rates of six hospitals and understated the rates of the remaining three hospitals.

⁵Five of the fifteen hospitals reported both unallowable wages and fringe benefit costs.

⁶Six of the thirteen hospitals reported both misstated and unsupported costs for contract labor services.

- Five hospitals included overhead costs for items such as travel and per diem and contract labor costs not directly related to patient care, which overstated their average hourly wage rates.
- Five hospitals excluded allowable contract labor services, which understated their average hourly wage rates.

Costs for Unallowable Part B Services

The Social Security Act and Medicare regulations provide that, as a general matter, the costs of services provided by nurse practitioners and physicians are covered by Part B, not Part A.⁷

The Manual, part II, section 3605, requires hospitals to exclude from their reported wage index information those physician, nurse practitioner, and other services that the hospitals claim for Part B reimbursement as patient services. Under Medicare, these services are related to patient care and are billed separately under Part B. The Manual, part II, section 2108, states that, to claim provider services under Part A, hospitals must distinguish these services from medical and surgical services rendered by a physician to an individual patient, which are reimbursed under Part B. An agreement between the hospital and the hospital-based physician on what services are Part A or Part B should be based on supporting documentation that is communicated to the hospital's intermediary.

Of the 21 hospitals reviewed, 5 incorrectly reported costs for physician and nurse practitioner services. These wage data reporting errors totaled \$10.5 million and 158,000 hours.

- Four hospitals could not provide support for recording physician and nurse practitioner services as Part A wage data, which overstated their average hourly wage rates.
- One hospital made a clerical error, which understated its average hourly wage rate.

Misstated and Misclassified Wages

The Manual, part II, section 3605.2, states that hospitals should ensure that the wage data reported on their Medicare cost reports are accurate. Further, it states: "Paid hours include regular hours (including paid lunch hours), overtime hours, paid holiday, vacation and sick leave, paid time-off hours, and hours associated with severance pay." Additionally, according to section 3605.3, each overtime hour is reported as 1 hour even when the employee is paid time and a half.

The Manual, part I, section 2182.3, states that physician compensation costs are monetary payments, fringe benefits, deferred compensation, and any other items of value (excluding office

⁷Section 1861(s)(1) of the Act and 42 CFR §§ 410.10(a) and 410.20 include care by physicians as covered Part B services; section 1861(b)(4) of the Act and 42 CFR §§ 409.10(b)(3) and 415.102(a) exclude physician services from Part A inpatient hospital services. Section 1861(s)(2)(K)(ii) of the Act and 42 CFR § 410.75 include care by nurse practitioners as covered Part B services; section 1861(b) of the Act and 42 CFR § 409.10(b) exclude nurse practitioners from Part A inpatient hospital services.

space and billing and collection services) that a hospital furnishes to a physician for services provided.

Of the 21 hospitals reviewed, 17 misstated or misclassified salaries and/or hours.⁸ These wage data reporting errors totaled \$9.3 million and 1.5 million hours.

- Thirteen hospitals included salaries without the related hours (e.g., severance and paid time off), which overstated their average hourly wage rates.
- Ten hospitals included hours for excluded cost centers and overhead, which overstated the average hourly wage rates at some hospitals and understated the rates at others.
- Three hospitals included overtime hours that were not reported as regular hours, which understated their average hourly wage rates.
- One hospital excluded allowable fringe benefit costs, such as Part A physicians' malpractice insurance costs, which understated its average hourly wage rate.

CAUSES OF WAGE DATA REPORTING ERRORS

These reporting errors occurred because the hospitals did not sufficiently review and reconcile wage data to supporting documentation to ensure that all amounts included in their Medicare cost reports were accurate, supportable, and in compliance with Medicare requirements. The fiscal intermediaries' cost report reviews did not detect the errors in the hospitals' wage data because their review procedures were generally limited in scope.

POTENTIAL PAYMENT INEQUITIES

The wage index affects Medicare payments to hospitals. Hospitals' inclusion of millions of dollars of unallowable costs in their wage data results in inflated wage indexes for those hospitals and, consequently, the inequitable distribution of Medicare payments to those hospitals and to all other hospitals. Additionally, the inclusion of unallowable costs in Medicare cost reports can compromise the reliability of the wage data that CMS uses to develop the market basket index and the labor-related share.

RECOMMENDATIONS

We recommend that CMS develop a corrective action plan to address hospitals' errors in reporting wage data. As part of its action plan, CMS should consider:

- ensuring that its FY 2007 wage indexes were adjusted, and its FY 2008 wage indexes will be adjusted, as appropriate, to account for the inaccurate wage data identified in our individual reviews;

⁸Eight of the seventeen hospitals made more than one type of wage data reporting error.

- working with its fiscal intermediaries to encourage hospitals to implement review and reconciliation procedures to ensure that reported wage data are accurate, supportable, and in compliance with Medicare requirements;
- alerting its fiscal intermediaries to the results of our reviews and recommending that they consider those results in prioritizing areas to examine in future cost report reviews; and
- working with its fiscal intermediaries to develop techniques for identifying hospitals at high risk of reporting inaccurate wage data and instructing the intermediaries to conduct more detailed reviews at those hospitals.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its comments on our draft report, CMS agreed with our recommendations and provided information on actions taken or underway to address hospital reporting errors. We have included CMS's comments as Appendix C.

CMS also provided technical comments, which we incorporated into this final report.

APPENDIXES

**OFFICE OF INSPECTOR GENERAL REPORTS
ON SELECTED HOSPITALS¹**

Report Title and Number	Issue Date
“Review of Cape Cod Hospital’s Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indices” (A-01-04-00501)	November 22, 2004
“Review of Windham Hospital’s Controls To Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes” (A-01-04-00511)	April 27, 2005
“Review of Hartford Hospital’s Controls To Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes” (A-01-04-00524)	June 29, 2005
“Review of Day Kimball Hospital’s Controls To Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes” (A-01-05-00506)	November 4, 2005
“Review of Saint Francis Hospital’s Controls To Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes” (A-02-05-01004)	April 25, 2006
“Review of North Shore University Hospital’s Controls To Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes” (A-02-05-01008)	May 4, 2006
“Review of Medicare Inpatient Wage Rate Assignment at Lehigh Valley Hospital, Allentown, Pennsylvania” (A-03-05-00003)	April 10, 2006
“Review of Medicare Inpatient Wage Rate Assignment at Hackettstown Regional Medical Center, Hackettstown, New Jersey” (A-03-05-00005)	March 30, 2006
“Review of Florida Hospital Heartland’s Controls To Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes” (A-04-05-02002)	May 24, 2006

¹These reports are available at <http://oig.hhs.gov>.

Report Title and Number	Issue Date
“Review of Controls To Report Wage Data at Citrus Memorial Hospital for the Period of October 1, 2002, Through September 30, 2003” (A-04-05-02003)	May 4, 2006
“Review of Sarasota Memorial Hospital’s Controls To Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes” (A-04-05-02001)	May 23, 2006
“Review of Riverside Medical Center’s Reported Fiscal Year 2003 Wage Data” (A-05-05-00022)	March 22, 2006
“Review of Condell Medical Center Controls To Ensure Accuracy of Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes” (A-05-05-00021)	August 29, 2005
“Review of the Hospital Wage Index at Baylor University Medical Center” (A-06-06-00038)	May 9, 2006
“Review of Valley Baptist Medical Center Reported Fiscal Year 2003 Wage Data” (A-06-06-00037)	May 20, 2006
“Review of St. Joseph Hospital’s Reported Fiscal Year 2004 Wage Data” (A-09-05-00040)	April 14, 2006
“Review of University of California, San Francisco Medical Center’s Reported Fiscal Year 2004 Wage Data” (A-09-05-00039)	September 18, 2006
“Review of University of California, Irvine Medical Center’s Reported Fiscal Year 2004 Wage Data” (A-09-06-00025)	September 15, 2006
“Review of University of California, San Diego Medical Center’s Reported Fiscal Year 2004 Wage Data” (A-09-06-00027)	September 14, 2006
“Review of University of California, Davis Medical Center’s Reported Fiscal Year 2004 Wage Data” (A-09-06-00024)	September 14, 2006
“Review of University of California, Los Angeles Medical Center’s Reported Fiscal Year 2004 Wage Data” (A-09-06-00026)	September 14, 2006

FACTORS CONSIDERED IN SELECTING HOSPITALS FOR REVIEW

Before selecting hospitals for review, we met with officials of the Centers for Medicare & Medicaid Services (CMS) to discuss CMS’s wage data protocols, fiscal intermediaries’ wage data review procedures, and aspects of hospitals’ reported wage data that are vulnerable to error. We then used a risk-based approach and considered several factors in selecting acute-care hospitals for review. As part of our risk assessment, we:

- determined which States had the largest percentage of Medicare hospital discharges;
- identified core-based statistical areas (CBSA) with wage indexes that were substantially higher than the average CBSA wage index in each of those States;
- identified hospitals that carried a significant proportion of the “wage data weight” (i.e., total salaries, wages, and hours) within those CBSAs;
- considered the number of Medicare discharges at each of those hospitals;
- identified hospitals for which reported wage data had certain high-risk characteristics (e.g., wage-related benefit costs exceeding 28 percent of salaries and significant contract labor or deferred compensation costs); and
- considered the number of hospitals in the CBSA for which reimbursement would be directly affected by the accuracy of the selected hospital’s reported wage data.

We also selected hospitals that were geographically dispersed.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN 10 2007

TO: Daniel R. Levinson
Inspector General

FROM: Leslie V. Norwalk, Esq.
Acting Administrator

SUBJECT: Office of Inspector General's Draft Report: "Review of Hospital Wage Data Used to Calculate Inpatient Prospective Payment System Wage Indexes" (A-01-05-00504)

OFFICE OF INSPECTOR
GENERAL
2007 JAN 12 PM 12:30

RECEIVED

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report entitled, "Review of Hospital Wage Data Used to Calculate Inpatient Prospective Payment System Wage Indexes." We appreciate the OIG's efforts to ensure the accuracy of the wage index and the appropriateness of Medicare payments for hospital services.

Section 1886(d)(3)(E) of the Social Security Act (the Act) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act.

The Act further requires that we update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report (Form CMS-2552-96), the Hospital Wage Index Occupational Mix Survey (Form CMS-10079), hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, we derive an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the Nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.

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In order for the Centers for Medicare & Medicaid Services (CMS) to comply with statutory and regulatory requirements pertaining to the wage index, CMS requires intermediaries to review and verify all inpatient prospective payment system (IPPS) hospitals' wage data before the data are used to calculate the wage index. CMS develops a wage index desk review program to guide intermediaries in their annual review of hospitals' data and supporting documentation.

The wage index desk review program is designed to check the clerical and mathematical accuracy of hospitals' wage index data. The program also includes guidelines for intermediaries to check that the wage data are developed appropriately according to Medicare wage index policies. The program is updated annually based on an analysis of the most recently collected and reviewed wage data and focuses on general categories of costs that potentially have the greatest impact on the wage index.

The OIG's draft report indicates that, for 2007, 21 hospitals reviewed by the OIG reported wage data totaling \$377.9 million that did not comply with Medicare requirements. The OIG found that the errors occurred because the hospitals did not sufficiently review and reconcile their reported wage data to supporting documentation to ensure that their data were accurate and in compliance with Medicare requirements. Additionally, the intermediaries' reviews did not detect the errors because their review procedures were generally limited in scope. We note that the OIG's audits were conducted on the cost report data only and did not include a review of the occupational mix survey data.

OIG Recommendation

Ensure that the fiscal year (FY) 2007 wage indexes were adjusted, and its FY 2008 wage indexes will be adjusted, as appropriate, to account for the inaccurate wage data identified in the OIG individual reviews.

CMS Response

The OIG found that hospitals reported inaccurate wage data totaling \$377.9 million. We note that \$326.4 million of this overstated amount was associated with pension and other post-retirement benefits. In the FY 2005 hospital IPPS final rule, we clarified that, as a result of the ongoing OIG review, pension and other deferred compensation plans must meet Medicare reasonable cost principles to be considered an allowable cost for the wage index. We received feedback from intermediaries that the OIG's FY 2007 wage index audits and the clarification made in the FY 2005 IPPS rule were very helpful and that recommended adjustments were included in the data submitted to CMS for the FY 2007 wage index. Although a number of hospitals appealed the fiscal intermediary adjustments on this issue, CMS upheld those adjustments as correct application of policy. For this reason, we believe that CMS has already taken action that addresses the vast majority of costs found to be reported inaccurately by the OIG.

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OIG Recommendation

Work with the intermediaries to encourage hospitals to implement review and reconciliation procedures to ensure that reported wage data are accurate, supportable, and in compliance with Medicare requirements.

CMS Response

We have noted this recommendation in the FY 2008 wage index desk review program. We agree that hospitals need to develop procedures to ensure that their wage data are accurate, supportable, and in compliance with Medicare requirements at the time they file their cost reports. To that end, CMS has recently stepped up its efforts to educate the provider community about the need for documentation. We will continue to encourage hospitals to work with their intermediaries to ensure that the methodologies they use to develop their wage data, and the documentation they maintain, meet CMS requirements for the wage index.

OIG Recommendation

Alert the fiscal intermediaries to the results of our reviews and recommending that they consider those results in prioritizing areas to examine in future cost report reviews.

CMS Response

In the FY 2008 desk review program, we informed all intermediaries of the OIG's audits and reports on the FY 2007 wage index and advised them to review and consider the OIG's findings in prioritizing areas to examine during their wage index reviews.

OIG Recommendation

Work with intermediaries to develop techniques for identifying hospitals at high risk of inaccurate wage data and instructing intermediaries to conduct more detailed reviews at those hospitals.

CMS Response

The CMS currently requires intermediaries to review all IPPS hospitals' wage data. Review of all hospitals' wage data is required because the wage index allows for geographic reclassifications of hospitals, which are determined based on a comparison of the requesting hospital's wages to the wages for the area to which the hospital wishes to be reclassified. Therefore, it is important for the fiscal intermediaries to continue reviewing, to some extent, all hospitals' wage data. Further, we work with intermediaries to prioritize problematic issues as they arise. For instance, to ensure consistency in the reporting of health insurance and health-related costs, we instructed intermediaries one

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year to do in-depth reviews on these costs for all hospitals. More recently, we advised the fiscal intermediaries to focus their reviews on pension costs when it came to our attention that these costs were being misreported. We acknowledge the advantages that more detailed reviews would provide. However, we must balance the need for more detailed reviews of wage data for specific hospitals with the need to ensure that the intermediaries review the wage data for all of the approximately 3,500 hospitals whose data we use to construct the wage index given the resources available to conduct wage data reviews. We will continue to work with the intermediaries to consider ways to prioritize issues or hospitals that should be subject to more detailed reviews to achieve greater accuracy of the wage index.

The CMS thanks the OIG for their efforts on this report. These findings provide us with helpful information we can use in our efforts to ensure the accuracy of the wage index and Medicare's payments to hospitals. We look forward to working together with you in the future as we further address the recommendations in this report.

We have also provided technical comments on the report.